Mental Health Services in Seattle
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INTRODUCTION

Just how strong is our commitment to our neighbors with serious mental illnesses that alter the course of their lives?

- Washington has made a commitment to shift the locus of public mental health services from state institutions to local communities, but we still have a higher percentage of our 120,000 clients in state hospitals than comparable states such as Oregon and Colorado.1

- King County, assisting over 23,000 clients with ongoing service needs, has developed a number of successful, innovative programs to assist clients with complex needs, but we are now cutting funding even for programs that reduce long-term costs of care.2

- We have changed involuntary treatment laws so that we can detain more people for longer periods of time if they have a history of assaults, but we are simultaneously reducing the number of long-term treatment beds available for these individuals.3

- Access to alternative providers, and the freedom to make our own choices about health care are things we value deeply, but we are hesitant to offer similar options to clients in the public mental health system.

Join us in an exploration of this vital public program. Learn how state services are structured, how services are provided at the county level, and what changes lie ahead. But first, a brief note about the people whom we are serving.

If you have a major mental illness, your life could be affected in any number of ways. You could be leading a successful, relatively normal life. Or your life could be completely derailed. Depending on the course of your illness and family circumstances, you might never be dependent on the public system. But for many who are unable to work, unable to pay for all of the treatment they need, or need other services such as housing and case management, the public system is their source of support. Unfortunately, resources in the public system are limited and some potential clients are turned away depending on their income and treatment needs. These people are referred to providers who charge sliding scale fees.

1. HISTORY

Individuals with mental disorders have lived in every society of which we have records, although communities have varied greatly in their responses to those we now label as mentally ill. In some societies, mental illness has been interpreted as possession by demons or spirits, and individuals with psychiatric symptoms have been feared and shunned. Other societies have been more accepting. Over the years, families and communities have struggled with how best to respond to people with psychiatric symptoms.

One early approach was to punish mental patients or to treat them brutally in order to free them from their symptoms. By the 1700's, in Europe, asylums were built for so-called "lunatics," mainly to remove them from society and protect the public. By the 1800's some asylums became safe havens with humane treatment provided, often by Quaker communities.

Terror acts powerfully upon the body, through the medium of the mind, and should be employed in the care of madness.

Benjamin Rush - 1812

If there is any merit in the management of the insane, it is this: respect them and they will respect themselves; treat them as reasonable beings, and they will take every possible pains to show you that they are such; give them your confidence, and they will greatly appreciate it, and rarely abuse it.

Samuel Woodward - 1830

The first psychiatric facility in Washington Territory was St. John's Hospital in Vancouver, operated by the Sisters of Charity. Western State Hospital was established after Washington Territory purchased Fort Steilacoom in 1870. Many people with serious and chronic psychiatric conditions were sent there. Eastern State Hospital was established in 1891, and Northern State Hospital in 1915. Initially, treatment was mainly "moral therapy" which meant humane care, recreation, the opportunity for religious participation, and work. At first, these hospitals were partly self-supporting. They had farms, dairies, and shops where the residents could work—an opportunity lacking in many programs today.4 Here, as elsewhere, the success of this approach to treatment was jeopardized by the increasing size of public institutions.

At institutions around the country, additional therapies were attempted over the years. Hydrotherapy, which began in 1911, placed patients in warm baths for their tranquilizing effects, but sometimes hydrotherapy was misused with less benign results. Induced insulin shock and electro-convulsive therapy (ECT) became common in the 1930's, and a form of brain surgery known as pre-frontal lobotomy appeared soon after. At first, many doctors were unaware of, or ignored, the trauma, the fatalities, and the permanent damage done to their
patients. Society's duplicity reached a pinnacle in 1949 when Egas Moniz won the Nobel Prize for Medicine for the development of the now discredited lobotomy.⁵

As these practices were evolving for institutionalized patients, various forms of psychotherapy were becoming popular for treatment of less disabling mental disorders. Sigmund Freud's revolutionary probing of the unconscious mind shocked many people, but various "talking cures" gained adherents. World War II gave impetus to the developing profession of psychotherapy as Veterans Administration hospitals trained many clinicians to work with psychiatric patients.

World War II also curbed the spread of the eugenics movement that had gained ground in the U.S. and other countries. Many states had passed laws prohibiting people with mental illness—among other undesirables—from marrying, while California led the nation in forced sterilizations. In 1927, the U.S. Supreme Court ruled 8-1 in Buck v. Bell that forced sterilization was constitutional. Oliver Wendell Holmes wrote, "It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind."⁶

Throughout the last century and continuing today, people concerned about the negative aspects of prevailing treatments have sought to assist mentally ill individuals in other ways. In the 1940s, before the advent of psychotropic medications, a group of mentally ill people established Fountain House, the first client-operated clubhouse, in New York City.⁷ There are now over 300 programs worldwide (though none in King County) that adhere to International Clubhouse Standards in which clients have access to transitional employment, a social support center, and responsibilities for all aspects of program management. Today, many clubhouse members accept the use of psychotropic medications, but believe that clubhouse participation facilitates their recovery.⁸

In the 1950's Drs. Abram Hoffer and Harvey Osmond developed orthomolecular treatments for mental illness based on vitamins and other natural substances.⁹ Claims that double-blind clinical trials document the success of this approach are ignored by many clinicians, but adherents work to ensure that thorough physical diagnosis and access to alternative treatments are available to clients concerned about long term use of medications. Locally, members of the Well Mind Association actively supported a King County ordinance to adopt a recovery model of treatment in the public mental health system.

The Soteria Project, begun in the 1970's by Dr. Loren Mosher, provided supportive treatment for young adults, recently diagnosed with schizophrenia, in a small homelike atmosphere with minimal use of psychotropic medications. Published reports indicated client outcomes comparable to those achieved with standard treatments, but funding was discontinued in 1983. Although no similar facilities are currently operating in the United States, several European countries have begun programs based on this model.¹⁰

As we contemplate the future, we need to be aware of our history. Abuses of the past, including forcing patients to submit to ineffective treatments with permanent disabling effects, and excessive reliance on physical restraints, continue to shape current debates about public policies affecting individuals with mental illness.

Movement out of institutions

In 1946, the National Institute of Mental Health was established as part of the US Public Health Service. NIMH sponsors research on the causes and treatments of mental illness. Serendipitous discoveries in the 1950's and later research by pharmaceutical companies led to the availability of numerous patent drugs that have dramatically changed the treatment of mental illness.

Once seriously disturbed institutionalized psychiatric patients could be managed with medication, expectations grew that they would be able to live at home, hold jobs, and live peaceful lives in the community—and some succeeded. Several factors contributed to the movement of patients out of large state institutions. Evidence of historical abuses, in combination with the civil rights movement of the early 1960's, contributed to the push for services in less restrictive settings. President Kennedy, three weeks before his death in 1963, signed into law the Federal Community Mental Health Center Construction Act, which gave a significant boost to the growth of facilities across the country. And beginning in 1965, Medicare and Medicaid funds could be used to pay for long term care in outpatient settings and nursing homes, but not in state mental hospitals.¹¹

Unfortunately, many newly discharged individuals had no suitable home to go to, had no job skills, and discontinued medications when on their own. Often the outpatient psychotherapists to whom they were referred were not trained to deal with serious mental illnesses. While the mental hospital populations were greatly reduced, those who were discharged often ended up on the streets, in jail, or in nursing homes.

II. MENTAL HEALTH SERVICES IN WASHINGTON STATE

Today, the Mental Health Division (MHD) of the state Department of Social and Health Services (DSHS) administers public sector mental health services. The MHD operates two state mental hospitals, funded
primarily by state dollars. It also contracts for local services, which are paid for primarily with federal and state Medicaid funds plus additional state funds for non-medical services such as residential support and crisis and commitment services. The state system serves approximately 120,000 people with a budget of over $550 million a year.  

In 1989, the legislature passed the Community Mental Health Services Act, providing for the establishment of county-based Regional Support Networks. The RSNs were to “help people experiencing mental illness to retain a respected and productive position in the community.” The 39 Washington counties are currently grouped into 14 RSNs. For the more populous counties, including King County, the RSN boundaries correspond to the county boundaries; other RSNs are multi-county entities.

RCW 71.24, the Regional Support Network (RSN) statute, requires that the publicly funded mental health system serve adults who are acutely, chronically, or seriously mentally ill, and children who have serious emotional disturbances. RSNs are directed to address the needs of underserved populations including “minorities, children, the elderly, disabled, and low-income persons.” Mental health services are provided through a certified vendor pool of community mental health centers. Services specified in the statute include: outpatient services; 24-hour emergency services; day treatment; screening for admission to state hospitals; employment services; consultation and education services; and community support services. The law also directs agencies to charge sliding scale fees to clients not entitled to Medicaid benefits.
Regarding involuntary treatment, the statute requires that RSNs provide, within their boundaries, evaluation and treatment services for at least 85% of persons detained under chapter 71.05 RCW—the state’s laws pertaining to involuntary commitment. In practice, this means that the state expects people detained for up to 14 days to be served within the RSN. People detained for 90 days, 180 days, or longer are generally sent to Eastern or Western State Hospital.

Despite the existence of the public mental health system, many people throughout the state have limited access to mental health services. In general, the public mental health system serves clients who are both very sick and very poor. The state’s 14 Regional Support Networks vary in their provision of services to clients who are not eligible for Medicaid, but recent changes in state funding have severely limited the ability of King RSN to serve non-Medicaid clients. People with a modest amount of income can sometimes pay for services on a sliding scale at community mental health centers.

Washington has not mandated parity in insurance coverage, so employer-sponsored health insurance might or might not cover treatment for mental disorders. No individual health insurance plan in Washington State provides any mental health coverage. Basic Medicaid, Medicare, the state’s Basic Health Plan, and health coverage through the state’s high-risk pool all have limitations on coverage for mental disorders. In addition to limitations in health insurance coverage, nearly all disability programs severely restrict payments for disability claims based on mental disorders.

III. KING COUNTY REGIONAL SUPPORT NETWORK (RSN)

In King County, oversight of mental health services and substance abuse services is combined under the Mental Health, Chemical Abuse and Dependency Services Division of county government. The MHCADSDS administers the county’s Mental Health Plan. In 2002, King RSN expenditures totaled $88 million. $60 million of this was state and federal Medicaid funds; $25 million was other state funds, federal block grants, special state allocations for services to a defined group of individuals (e.g., mentally ill offenders), and local funds; $3 million was from operating reserves, and $0.4 million was from the county general fund. Currently state funds are allocated on a capitated basis according to the number of Medicaid clients in the county (about 175,000 in King County), regardless of whether each of those clients needs or receives mental health services.

With these funds, King RSN served over 33,000 people. Of this number, 23,269 clients received outpatient services on an ongoing basis. The total number of clients served in outpatient programs declined by nearly 6% in 2002. The number of non-Medicaid clients in outpatient programs declined by 25% to 1466 as a result of changes in the state funding formula that resulted in lower than anticipated revenues to the RSN.

Approximately two-thirds of the RSN budget is paid to seventeen agencies (community mental health centers) that serve clients with ongoing service needs. When clients’ needs are assessed, they are assigned a tier level that indicates the amount of services they are likely to need. The agency that enrolls the client then receives funding for serving that person for the next twelve months. Larger agencies, such as Seattle Mental Health and Community Psychiatric Clinic, utilize multi-disciplinary teams that include case managers, substance abuse and vocational counselors, psychiatrists, RNs, nurse practitioners, and residential program managers. Several members of a team may serve clients with complicated needs. There is considerable value in this approach, but it then becomes difficult to track case loads as one client will appear on the case load of several providers.

Agencies are paid a case rate for each “tiered” client with the rate increasing according to the tier level. Currently King RSN uses four tier rates, although this may change. The tiers are: 1b—Maintenance; 2—Stability Services; 3a—Rehabilitative Care; and 3b—Exceptional Care (note: 1a has been discontinued.) Once a client is assigned to an agency, that agency then assumes financial responsibility for all outpatient care provided to the client for the coming twelve months. Services are to include those that are outlined in state statute. As funding fails to keep pace with service needs, the RSN is focusing its attention on clients with the greatest need, so fewer and fewer people in lower tiers are receiving services.

It is difficult to provide a “picture” of outpatient services. Intentionally, they vary greatly depending on client needs. In general, however, clients have limited access to psychiatrists and psychotherapists. Medication management is done primarily with nurse practitioners, with occasional visits with a psychiatrist. Clients have the most contact with case managers who assist them with goal setting and problem solving. In most agencies, substance abuse treatment is separate from mental health services.

About one third of funds are spent on administration, inpatient care, and a variety of special “carve out” services. These are programs that were created to coordinate services, address gaps in service, or serve the needs of individuals who are not currently receiving tiered services. Examples include the Crisis and Commitment Services (CCS), the Crisis Clinic 24-hour crisis line, the Crisis Triage Unit (CTU) at Harborview Medical Center,
special staff to serve mental health clients at the county detoxification center, special contracts for respite beds for children, respite beds for adults, reserved next day appointments for people with urgent needs, hospital diversion beds, liaison services with correctional facilities, and the ombuds service.

The Crisis and Commitment Services program is staffed by 28 County Designated Mental Health Professionals (CDMHPs). In Washington State, these CDMHPs are the only people who can write an initial order for detention under the state’s Involuntary Treatment Act (ITA) (RCW 71.05). These services are available 24 hours per day, 7 days per week. All voluntary inpatient treatment for enrolled RSN clients must be authorized by staff of the Crisis Clinic. The Crisis Clinic also answers distress calls 24 hours a day for all residents of King County.

The Crisis Triage Unit at Harborview is a pilot program attempting to provide a single point of entry for people needing multiple services. The CTU has special staff trained to assist people needing access to mental health, substance abuse, and developmental disability programs. People may be directed to an inpatient facility, outpatient program, shelter, or other services.

One of the ways King RSN meets the needs of the special populations identified in the authorizing legislation is by contracting with agencies with specialized services or expertise in serving certain groups of people. Examples include Asian Counseling and Referral Service, Consejo Counseling and Referral Service, Seattle Children’s Home, Therapeutic Health Services, and Downtown Emergency Services Center. As we learned from the League’s study on Alternatives to Juvenile Detention, there are several multi-agency programs to provide intensive support to children and families needing a variety of services.

In addition to contracting with specialized agencies, the RSN works with other community resources to assist clients with special needs. These partnerships occur with other DSHS divisions and administrations including: Developmental Disabilities, Alcohol and Substance Abuse, Vocational Rehabilitation, Children and Family, Aging and Adult, Juvenile Rehabilitation, and others. Outside of DSHS, partnerships occur with the Department of Corrections, Department of Health, local schools, local juvenile facilities, advocacy groups, and others. The goal is to combine efforts and resources to help people succeed in their home community.

IV. ISSUES CONFRONTING COMMUNITY SERVICES

A. Fragmentation

From the perspective of an ordinary citizen trying to gain an understanding of our public mental health system, the system appears to be severely fragmented. Given the many different agencies and programs providing services, it is no wonder that clients and family members are confused and bewildered, or that service providers have difficulties accessing and coordinating services. This fragmentation contributes to continuing concerns of clients and advocates regarding crisis services and coordination between inpatient and outpatient providers.

The RSN is paying attention to both issues. Agencies are responsible for developing a crisis plan with each client, although smaller agencies might contract with other agencies for after-hours service. Also, the RSN has contracted with Community Psychiatric Clinic to coordinate discharge planning between all inpatient facilities and outpatient providers. In addition, special multi-agency programs have been created to try to pull together services to assist clients, including children and families, with complex needs. The concern is not that any one of these agencies or programs is bad or deficient, but merely that the fragmentation and complexity, in and of itself, seems more likely to create barriers than to facilitate access to services.

Although one value of such a complex delivery system might be ease of innovation within smaller agencies, a limitation is that it is very difficult to create a unifying vision or sense of purpose at the county level. The RSN serves as a contracting agency, but does not actually manage the services. Hence there is no direct link between the leadership and the people on the front lines assisting clients on a daily basis. The result is that there is no easy mechanism by which the system can be led in one direction or another. RSN administrators attempt to address this problem by involving stakeholders, including agency and program representatives, client representatives, and advocates in meetings that focus on budget and program issues. Still, it is natural for the many different agencies to resist changes that might threaten their own programs and staff. It is, indeed, a challenge to make the elephant dance.

B. Funding and Accountability: The JLARC Report

State budget woes are well known. The state economy is languishing and we are in a period of resistance to statewide taxes. Additionally, RSNs are being affected by a legislative decision to reduce mental health funding to some parts of the state and increase funding to other areas. This decision followed a 1999 study, the Mental Health System Performance Audit, by the Joint Legislative Audit and Review Committee (JLARC).

These studies found significant discrepancies in service patterns and funding for the various RSNs that could not be adequately explained by cost-of-living differences, wages, client needs, or other factors. Funding to the RSNs had been computed on a complicated capitated
basis that was derived from historical fee-for-service payment patterns. However, the performance audit found that expenditures per client served varied from $1344 in Southwest RSN to $3965 in King RSN. Total funding per Medicaid eligible person varied from $271 for Timberland RSN, in southwest Washington, to $332 for King RSN.

Local administrators cite two factors that contributed to such a large discrepancy in funding. Years prior to the implementation of the capitated funding formula in 1995, the state had shifted responsibility— and funding— for contracting for Evaluation and Treatment beds to King RSN. Likewise, the state used to contract directly with residential treatment programs, but transferred this responsibility— along with funding— to King RSN in the early 1990’s. Little documentation remained of these funding changes, however, and these explanations were not included in the final report.

After viewing the report, the legislature decided to gradually implement a different funding formula over a six-year period that would substantially reduce the noted disparities. This change means that state funding to King RSN will not increase as expected, and may actually decline beginning in 2004. The result of this change in funding is that King RSN is steadily reducing the number of non-Medicaid clients it will serve, raising the threshold of severity for Medicaid clients, and looking at a number of other program changes.

A controversial part of the report was a prevalence study to estimate the number of mental health clients in the various service areas. This was done through a statewide telephone survey of 7000 families. On the basis of this phone survey, the state determined that the county’s Medicaid eligible population was an adequate indication of the number of clients likely to need mental health services. King County strongly objected to using this data to determine funding on the grounds that it could not account for “urban drift” of clients with high service needs who congregate in urban centers because of the variety of services available there. The legislature has agreed to gather additional data and results are expected in fall of 2003.

Aside from the funding issue and prevalence study, the audit contained a number of recommendations related to system accountability. The state found that RSNs had no standard way of accounting for services and had no outcome measures to indicate their success in helping clients. Many of the recommendations were for changes in the way the Mental Health Division works with other agencies and tracks service and client outcomes.

Meaningful data to show state funding changes over time are difficult to construct. The RSN has only recently maintained an unduplicated count of clients. Agreements between the state and the RSN about which services will be paid by each have changed from year to year. Funding increases due to increases in Medicaid enrollment are deceptive since service needs also increase, but not necessarily at the same rate. Also, the state may alter Medicaid contracts, so that even though an RSN receives more money, agencies providing services may receive less for certain services. The resulting apples and oranges comparison of annual funding makes it difficult to evaluate the adequacy of funding. It is also difficult to compare case loads over time given that the many different agencies have different service models, many use multi-disciplinary staffing teams with overlapping case-loads, and several multi-agency programs have been created for special needs clients. Still, it is fair to say that agencies and residential facilities feel that their resources are being stretched further and further each year.

Data do show significant increases in expenditures for mental health services at the state level since 1989, as well as the enormous pressure placed on the state budget from the rising costs of the medical assistance program (Medicaid).17

C. Oversight

A number of mechanisms exist for oversight of public mental health services, although there are questions as to their effectiveness. At the state level, the DSHS Division of Mental Health has a consumer oversight board and funds the Office of Consumer Affairs. Federal law requires each state to have a protection and advocacy agency to address the needs of vulnerable populations, specifically individuals with mental illness or developmental disabilities. In Washington, the Washington Protection and Advocacy System (WPAS), established in 1972, receives federal funds to fulfill this mission. WPAS primarily focuses on conditions at the state hospitals and institutions.

In addition, each RSN is required by state statute to have a Quality Council to review system wide quality of service issues, and an independent ombuds service to address individual complaints. King RSN employs two clients to serve as the Quality Review Team and present client concerns to the Quality Council. As employees of the agency they are monitoring, it would be difficult for the Quality Review Team staff to seriously challenge RSN policy. Still, they regularly obtain feedback from RSN clients through on-site visits to each agency and also by conducting surveys on issues that arise from these individual conversations. In addition to annual Client Satisfaction Surveys, the QRT recently conducted surveys about after-hours crisis services (February 2000) and case manager concerns (September 2000). The Quality

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Council sponsored a subsequent report on case manager turnover that was completed in January 2001. Data indicated that turnover in local mental health agencies was higher than national averages.¹⁹

The RSN also has a Mental Health Advisory Board and a Substance Abuse Advisory Board with community members appointed by the County Executive. These boards meet monthly, but are advisory only and have limited impact on services. Attendance is inconsistent, positions are often vacant, it takes months for appointments to be approved, limited information is available to members, and little homework is done between meetings.

King RSN issues quarterly and annual “Report Cards” that include financial and service data. The report cards track the number of clients served according to tiers and demographics, outcome data intended to show whether or not clients are improving and moving toward independence, and system success in reducing inpatient stays and seeing clients soon after discharge from a hospital or release from jail. Although the data is extensive, it is also confusing. For example, it uses different measures to track voluntary and involuntary utilization, thus making a direct comparison impossible. Recent outcome data shows that homelessness, employment, and incarceration rates have not improved, but service issues such as time lag for initial appointments have improved.

The National Alliance for the Mentally Ill (NAMI), an advocacy organization founded by families, has active state and local affiliates including NAMI Greater Seattle, NAMI Eastside, and NAMI South King County. Washington lags behind other states in the development of a consumer council within NAMI-WA, but efforts are underway to accomplish this. A strong, independent CSX (consumer, survivor, ex-patient) movement is also lacking in the state, so to date, the primary advocates for clients are family members.

D. Involuntary Treatment

There are two issues related to involuntary treatment of individuals with mental illness: detention in a hospital, state institution, or evaluation and treatment facility; and forced treatment with drugs, restraints, and ECT or shock-therapy. The laws regarding detention offer more protection than the laws regarding treatment. Patients' lack of control over treatment decisions under involuntary status contributes to their resistance to detention. Patients detained under provisions of the Involuntary Treatment Act (ITA) have fewer rights than people who are incarcerated.¹⁹

1. Involuntary Treatment: Detention

Washington State's current law regarding civil commitment of individuals with mental illness—first passed in 1973 and amended in 1989, 1997, and 1998—struggles with conflicting public and individual rights. The stated intent of RCW 71.05 is:

1. To prevent inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment.

2. To provide prompt evaluation and timely and
appropriate treatment...

3. To safeguard individual rights...

4. To provide continuity of care...

5. To encourage the full use of all existing agencies...to prevent duplication of services...

6. To encourage... that services be provided within the community

7. To protect the public safety.

Historic abuses of individuals with mental illness led to this legislation specifying the rights of individuals and establishing criteria under which a person could be held involuntarily. Initially, the law required evidence of imminent threat of harm to self or others, judicial review, and limitations on length of commitment. Concerns of family members and advocates led to an amendment in 1989 to allow the detention of “gravely disabled” individuals who did not pose an imminent threat of harm. The law was further amended after individuals with a history of assaults—but no evidence of an “imminent” threat—committed further crimes, including murder, after being released. Today the law allows a person’s history to be taken into account when determining whether or not a threat to the community exists.

In Washington State, only County Designated Mental Health Professionals (CDMHPs) determine if a person may be detained involuntarily. The involuntary treatment process for adults begins when someone asks for an evaluation by a CDMHP. These requests may come from friends, family members, anyone in the community, health care professionals, or police officers. Except for health care professionals or police, calls for assistance generally come through the Crisis Clinic 24 hour crisis line. Crisis line workers determine if an assessment is appropriate, then place a call to the CDMHP staff. The phone number of the CDMHP office is not readily available to the public.

People detained for evaluation are taken to the Crisis Triage Unit at Harborview. Most individuals facing the possibility of involuntary treatment are represented by counsel from the Public Defender’s office. Court hearings must be held according to strict timelines in order for involuntary detention to be continued. Initial holds are for 72 hours, but a judge may order additional detention for 14 days, then 90, then 180 days. Patients may be discharged under Less Restrictive Orders (LROs) requiring them to comply with an outpatient treatment program for 90 days (180 days for juveniles). Failure to comply may result in the person’s return to an inpatient facility.

The state law authorizing creation of the RSNs requires that 85% of individuals detained for up to 14 days must be cared for in community facilities, but King RSN has long exceeded this requirement. King RSN contracts with four facilities to treat patients on an involuntary basis: Harborview; West Seattle Psychiatric Hospital; Fairfax Hospital (for children and adolescents) and Northwest Hospital (for older adults). If no beds are available locally, patients may be sent to Western State Hospital. Patients charged with felony assaults or other serious crimes may be sent immediately to the forensic unit at Western State Hospital.

Provisions for involuntary treatment for juveniles are slightly different. Criteria for commitment are the same as for adults, but the age of consent for treatment is 18. Parents can sign a child, through age 18, into a hospital without the child’s consent, but the hospital is not required to accept the child as a patient.

2. Involuntary Treatment: Forced Medication

Involuntary treatment by its nature is controversial. With any other medical condition, you may refuse treatment and, unless highly contagious, continue living among us or apart from us, with or without treatment, as you choose. You will likely be offered treatment options, and may even choose to let an illness end your life. However, when someone whom we consider to be mentally ill disagrees with our assessment of their needs, we challenge their right to refuse treatment on the grounds that the illness has robbed them of the ability to understand their condition and make appropriate decisions about their treatment. Many individuals who have been treated against their will later come to appreciate the treatment. Others, including some who continue with treatment on an outpatient basis, regard their involuntary experiences as deeply humiliating and abusive.

Although we might assume that voluntary treatment is preferable, public defenders are involved in considerable negotiations regarding admission status. Facilities generally require voluntary patients to sign a pledge that they will not harm themselves during their stay. So a patient may acknowledge a need for help, but be honest about suicidal intentions and thus be refused voluntary status. Also, patients who enter treatment on a voluntary basis have the right to informed consent regarding treatment options and may leave when they choose. Inpatient providers may resist voluntary status because they want to control treatment decisions. In Washington State, patients admitted under provisions of the Involuntary Treatment Act (ITA) have no right to judicial review of treatment decisions until they have been detained for 30 days.

A major concern of clients, public defenders, and advocates is the lack of sensitivity, on the part of
providers, to patient concerns about medications. A wide variety of psychotropic medications are available today and individual patients respond very differently to these drugs. Drug companies downplay concerns, but gradually we are learning of long-term health risks associated with these drugs, including newer medications. Patients want the right to informed consent, and they want to be taken seriously when they express concerns about psychological and physical effects of medications. Some are also seeking providers who will support their desire to explore alternatives to life-long dependence on these medications.

Parents seeking treatment for adult children are troubled by the adversarial nature of the commitment hearings and the fact that hospitals can refuse to accept patients who agree to treatment on a voluntary basis. The need to testify against their child is the source of much of the pain, and often alienates the very person they are trying to help. Washington, along with many other states, continues to struggle with the issue of involuntary treatment, striving to balance concerns of family members, the community, and individuals with mental illness.

3. Involuntary Treatment: Standards

King County has long been regarded as one of Washington's most difficult locations in which to get an order for involuntary treatment for a family member. Advocates' concerns about the use of different standards in involuntary treatment decisions led local County Designated Mental Health Professional (CDMHP) staff to investigate the matter. They did this by sending a variety of individual case descriptions to CDMHP staff in other RSNs and asking them to indicate whether or not they would commit the individual for treatment. The results showed that decisions of local CDMHP staff did not differ significantly from their counterparts in other parts of the state. The study was not able to ascertain the effectiveness of public defenders throughout the state in preventing involuntary commitments, but King County clients are represented by highly experienced public defender law firms.

4. Involuntary Treatment: An Unfunded Liability

The recent changes allowing a person's history to be considered in Involuntary Treatment Act (ITA) decisions have resulted in more people being detained in inpatient settings for longer periods of time, exactly the outcome desired by the public. Data collected by Ammon Schoenfeld when he served as Director of Crisis and Commitment Services show the impact of these changes statewide. Unfortunately, funding has not kept pace with the demand for lengthy, high-cost inpatient treatment, and just as the public is demanding that potentially dangerous patients be detained for longer periods of time, the state is reducing the number of beds available for longer term treatment at the two state hospitals. At some point, a lawsuit may be necessary to resolve the tension between the state and the RSNs over this matter.

E. Interactions with the Criminal Justice System

Individuals with mental illness may have encounters with law enforcement officers and courts for any number of reasons. When County Designated Mental Health Professionals (CDMHPs) are asked to evaluate someone for involuntary treatment, they may ask for police officers to accompany them if the person has previously exhibited threatening behavior, or they may call for assistance if a person will not accompany them willingly. If a person is directed to appear for a competency hearing and fails to appear, a warrant is issued. If a person is threatening suicide, police may respond. People needing treatment

![Increase in Involuntary Commitments](image-url)
may commit major or minor crimes, or just frighten others with bizarre behavior. The point is that even though the underlying problem might be a medical one, when safety is at stake, armed police officers respond.

1. SPD Crisis Intervention Team

The result of these encounters between mentally ill people and the police has sometimes had tragic consequences. The Seattle Police Department has responded with the creation of the Crisis Intervention Team. CIT members are patrol officers who volunteer for 40 hours of additional training in ways to work with people who might be mentally ill. Sgt. Liz Eddy coordinates the training that provides background information about mental illness and practice in de-escalating situations that might lead to violence or suicide. Currently about a third of SPD’s patrol officers have received this training. If officers responding to a situation have not been through the CIT training, they are encouraged to ask for back up by CIT members when appropriate. Other communities are beginning to offer similar training opportunities to their police officers.

If a crime has not yet been committed, but an officer is concerned about an individual, any police officer may detain an individual at the Crisis Triage Unit at Harborview for evaluation. If this evaluation does not occur within 12 hours, the individual must be discharged according to ITA rules unless he or she agrees to stay longer. If CDMHPs determine there is a need for involuntary treatment, then the provisions of the 72-hour hold and hearing requirements apply.

2. Jail Psychiatric Services

When a person has committed an actual offense, be it a misdemeanor or a felony, and is taken to a corrections facility, the booking officer conducts an initial screening for signs of substance abuse or mental illness. Studies indicate that over 60% of inmates test positive for drug or alcohol use at time of booking. Sometimes people are sent directly from the jail to the Crisis Triage Unit at Harborview for pre-booking diversion to a treatment program. Once inmates are booked into jail, they may be referred for additional evaluation by Jail Psychiatric Services, funded by the King County Public Health Department.21

Approximately 15% of individuals booked into King County correctional facilities receive a more thorough evaluation by a Psychiatric Evaluation Specialist. In King County, about 60,000 bookings occur each year, and about 9,000 individuals receive additional evaluations. Of those receiving this additional evaluation, about a third, or 3,000 inmates (approximately 5% of all inmates), are determined to have a serious mental disorder that merits ongoing treatment. Some are then housed in the jail’s psychiatric unit, but each day 150-250 of these inmates are functioning well enough to stay with the general population. Inmates who might be at risk of suicide, whether or not they have a serious mental illness, are housed in special cells. In King County facilities, about 50 inmates are on suicide watch each day.22

Inmates needing psychiatric medications receive them on a voluntary basis, as part of health services available to all inmates. Very limited counseling services are available. The RSN has been working to improve communications with jail staff about inmates who will need RSN services when they are released, and agencies now track their success in connecting with these clients soon after they leave the jail.

3. Mental Health Court

If individuals with a major mental illness are charged with misdemeanor offenses, they may be eligible to have their cases transferred to a Mental Health Court. Both the
City of Seattle and King County have established Mental Health Courts with the hope of keeping mentally ill people out of jail. The trade-off, however, is compliance with a treatment program. Some individuals, including some facing short sentences and others who resist forced treatment, decline the mandatory treatment option that entails forced medications. Perhaps with additional treatment choices, more people will opt for the services of the Mental Health Court. In December 2002, one client, with the help of legal counsel, was assigned by the Mental Health Court to complementary orthomolecular treatment as an alternative to traditional medications. Indications are that the Mental Health Courts do not necessarily reduce time in jail for the current offense, but do decrease future bookings by linking people with outpatient services. In Mental Health Court, failure to comply with a treatment program results in the person being returned to jail.

V. EXEMPLARY PROGRAMS

King County RSN has a number of innovative programs with demonstrated success in serving clients with complex needs. We cannot go into detail about all of them, but we have selected some programs that demonstrate the county’s efforts to provide services to clients with special needs.

A. Bridgeway Recovery Program

Bridgeway Recovery Program, a division of Community Psychiatric Clinic, offers one of the few integrated programs for co-occurring disorders in this area. For a variety of historical reasons that have nothing to do with the current needs of real clients, mental health and substance abuse treatment programs have different cultures, different funding streams, different laws regarding confidentiality of client records, and different bureaucracies at the state and federal levels, making it difficult to assist clients needing both kinds of service. King County is unusual in that it administers both programs under the Mental Health, Chemical Abuse and Dependency Services Division within the Department of Community and Human Services.

Estimates are that as many as 50% of individuals with a serious mental illness may have substance abuse issues. Yet it is common for a mental health provider to expect a client to be clean and sober, or for a substance abuse program to turn away a client with a mental illness who can’t “engage” in the recovery process. Seattle is fortunate in having leading researchers in the field and providers offering services structured specifically for clients with co-occurring disorders.

At Bridgeway, providers are trained in both fields and expect to work with clients over a long period of time as they come to terms with their mental illness and begin to address substance abuse issues. Their approach to clients is less confrontational than in most substance abuse programs, they work with both mental health and substance issues simultaneously, and clients attend separate support groups where they are free to discuss concerns related to their mental illness with others who can appreciate their experiences. Other agencies are contemplating similar programs.

B. Programs for Mentally Ill Offenders

Washington is one of many states with very high standards for the defense of not guilty by reason of insanity (NGI). In essence, people who have any awareness that their actions were “wrong,” or against the law, cannot use this defense. As a result, many people with serious mental illnesses serve time in jail or prison. In 1997, the Community Mental Health Services Act was amended to establish a pilot program for mentally ill offenders (RCW 71.24.450). With funding from a special state appropriation, King County RSN, Seattle Mental Health, Pioneer Human Services, and Therapeutic Health Services collaborated in developing the Mentally Ill Offenders Community Transition Program (MIOTCP). This program offers intensive support for 25 individuals with a history of mental illness due to be released from a state correctional facility. The goals are to develop strategies to “reduce incarceration costs, increase public safety, and enhance the offender’s quality of life.”

This program is in its fifth and final year. The December 2002 report to the legislature documents the process for selection of participants and the spectrum of services offered to participants in the program. Department of Corrections (DOC) staff screen potential candidates and refer interested individuals to the program. Case managers from the program interview candidates; then DOC and RSN staff make the final selection. Pre-release planning is a crucial element of the program. Participants meet with providers for assessments, planning for services after release, arranging housing, and completing applications for temporary income support, disability programs, and Medicaid. Services begin on the date of release.

Data from the first four years of this program show that subsequent incarcerations, inpatient stays, and substance abuse relapses are substantially reduced for program participants when compared to similar offenders not involved in the program. Each year the provider team has made adjustments that have improved their success rate over prior years. Now, however, the strategies developed in this pilot program will be utilized statewide for up to 180 offenders who have committed more serious crimes. Unfortunately, not all of the people who are part of the pilot program will be eligible for services under the new program.
The new Dangerous Mentally Ill Offenders (DMIO) program offers comprehensive support to inmates with serious mental illness or developmental disability and a record of assault, murder, and Level II and III sex offenses. The program provides funding of $10,000 per year per participant for five years, in addition to the RSN tier benefit. Program elements that contribute to successful reintegration for these individuals are comprehensive pre-release planning, continued supervision by the Department of Corrections, access to affordable, appropriate housing, and intensive support by community treatment teams.

One of the greatest barriers to success is the lack of housing in "healthy" neighborhoods where participants can find support for changing old patterns of behavior. Sex offenders face special restrictions on where they can live, but many landlords are reluctant to offer housing to anyone with a DMIO label. Funding, though generous by some standards, limits housing options, especially in expensive urban counties. Also, few participants have access to a social network that includes people not in similar circumstances or people who are not "paid to talk to them."

The RSN works with the Department of Corrections to identify other mentally ill inmates before they are released. A referral process for Seriously Mentally Ill Offenders (SMIO) has been developed to facilitate transition to community services, however, no special funding is provided to pay for extra support except for the DMIO program. The question, as with all such programs that demonstrate the value of intensive support for high-risk populations, is whether we will continue to pay for them. If a program saves money in the long run, will we pay for it in the short run? Does the improvement in the quality of life for the participants enter into the equation at all?

C. HOST—Homeless Outreach Stabilization and Transition

All of the shelters and programs of the Downtown Emergency Services Center (DESC) are targeted at the county's most challenging population. These are people with complex needs who lack trusting relationships with family, friends, or agency staff who might assist them. Using an outreach and engagement model of service, HOST case managers seek out clients on the streets, in hospitals, in libraries and other areas where they might be found. People are encouraged to use the drop-in center where they can become acquainted with staff members. By engaging people gradually, on their own terms, case managers build trust by offering to assist clients with needs that the client identifies. The goal is to help stabilize people, then help them transition into programs that provide secure housing and ongoing clinical services.

D. High Utilizer Program at Harborview

Certain "high utilizers" of mental health services engage repeatedly in self-harming behavior resulting in frequent inpatient stays. Many of these individuals do not respond well to medications that help stabilize others, thus making them a challenging population to serve. In the past decade, Marsha Linehan, Ph.D., a research psychologist at the University of Washington, has developed a highly structured form of psychotherapy, called Dialectical Behavioral Therapy (DBT), that has proven successful in working with these clients who are often labeled with Borderline Personality Disorder.

Harborview's High Utilizer Program successfully uses DBT and other skills training to enable clients to alter chaotic behavior patterns, thus improving their quality of life and reducing inpatient stays and incarcerations. Key elements of this intensive year-long program are a willingness for members of the provider team to be available to clients at any time, training in specific strategies to address anxiety and negative self-talk, continual affirmation of the strengths of the client and their success in changing their behavior, and easy access to inpatient beds when clients need that level of care. Despite its high cost, the DBT clinic has proven to be cost-effective, since clients that complete the program need fewer services in the long term. Still, funding for the program was reduced for 2002 due to lower overall funding to the RSN.

E. Transitional Resources: Community Integration Program for Clients with Treatment-Resistant Schizophrenia

Another exemplary program based on a recovery model of services is Transitional Resources (TRY). TRY House is the agency's 16-bed long-term residential facility, however, the "16th bed" is available to RSN clients for short-term stays as a hospital diversion alternative. The House provides intensive supervision, medication and case management, training in adult skills of daily living, and supported employment and education. TRY's other residential services program provides supported living apartments and houses with varying degrees of independence. Priority for admission is given to people coming from Western State Hospital, local inpatient psychiatric units, correctional facilities, the homeless, high utilizers of RSN services, or those failing in current treatment programs.

The agency has vocational rehabilitation services with employment at their facilities and in the community. They have a horticulture training program and a greens-to-market project in the backyard of TRY House, and offer supported employment opportunities through local employers.
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The program works to remove barriers that affect people with mental illness, such as discrimination in the workplace and resistance to group homes in residential neighborhoods. This is done by educating employers as to the strengths and needs of their mentally ill employees. Staff members also meet with concerned neighbors to explain the way the agency supports clients in off-site housing.

The reduction in the cost of care for clients under this model of extensive support is considerable. In state mental hospitals where most of these clients have been, the cost is $150,000 a year per client. The TRY House residential program cost is $36,000 per year. In their supported living houses and apartments the cost is $7000 a year. TRY’s community based residential housing has allowed people to start on their road to recovery and wellness and to lead happier, more satisfying lives. The range of supported living options allows clients who do not initially succeed in more independent settings to move back to settings with greater support or closer proximity to staff.

Similarity to PACT programs

The services provided by Transitional Resources approximate a model of care referred to as PACT, or Program for Assertive Community Treatment. PACT programs are highly regarded by many family members of people who “opt out” of less intensive programs. The PACT model was developed thirty years ago in Wisconsin by a group of providers who wanted to offer a high level of support to clients in a community setting. A true PACT program would have a higher staffing level and would not utilize a long-term rehabilitation (LTR) facility. Rather, it would rely only on community housing with staff support available 24 hours a day. As with Transitional Resources, however, the emphasis is on medication compliance, working with clients to strengthen social skills, integration into community activities, and supported employment.

VI. FUTURE DIRECTIONS

A. Implementing a Recovery Model of Services

On October 16, 2000, the King County Council passed Ordinance #13974 intended to promote recovery as an achievable outcome for adult clients of the publicly funded mental health system. Recovery is viewed as a treatment philosophy and a process by which clients move toward greater independence. The RSN is now required to report to the council outcome measures reflecting changes in clients’ level of functioning, housing, and employment. The same measures used for that report appear in the quarterly and annual RSN report card.

The recovery model, on which the King County Ordinance is based, differs from a traditional medical model both in assumptions about a client’s prognosis and in the involvement of the client in treatment planning. In the past, the client was a relatively passive recipient of case management emphasizing medication and entitlements (housing, Medicaid, and disability payments) with a goal of stabilization. Low expectations became a self-fulfilling prophecy. In the recovery model the clients are able to participate in treatment decisions and explore alternative treatment options. They develop goals for housing, education, community participation, and employment. The goal is increased independence and wellness. Instead of a focus on the process and illness, emphasis is on the whole consumer–their strengths, individual needs and outcomes.

Data collected in response to the ordinance will compare the outcomes of different programs so that best practices can be identified in King County. Recovery model programs worldwide, implemented with intensive case management and coordinated systems of treatment services with reevaluation and adjustment, have demonstrated superior outcomes and reduced relapse rates.

B. Focus for Change

King RSN is focusing on four goals considered essential in aligning services with a recovery model. It seeks to provide housing alternatives that balance client needs for support and independence; increase opportunities for paid employment outside of mental health facilities; reduce incarcerations through better coordination with correctional facilities and targeted outpatient programs; and make integrated substance abuse and mental health services available to more clients.

C. Vocational Services

The RSN Vocational Services Plan was developed in response to a dramatic decline in the percent of clients who have some paid employment. In 2001, 15% of clients had some paid employment, but in 2002, this number declined to 9%. Although it would be easy to blame “the economy,” the plan notes several other factors including the end of funding agreements between the state Division of Vocational Rehabilitation (DVR) and the RSN, changes within DVR, and a lack of vocational certification by mental health provider agencies. The plan notes ample evidence that clients who engage in paid work in settings apart from their mental health agency have improved long-term outcomes. It makes several recommendations, including renewed linkages with DVR and the creation of several Regional Employment Services and Placement Centers that could provide Supported Employment services for clients from any mental health agency. The most important change is a system-wide commitment to employment as an achievable outcome for most clients.
D. Housing Resources

The RSN Statement of Policy Intent for Residential Services is also in line with the recovery model. The county proposes to move as many clients as possible from facility-based residential beds to scattered site housing with flexible supports. The statement recognizes the need to make changes gradually while providing transitional services to clients moving from supervised to independent housing. It also recognizes that some clients may need to stay in supervised facilities for a period of time.

Currently the RSN funds two levels of facility-based residential care, Long Term Rehabilitation (LTR) beds, and Supervised Living (SL) beds. LTR facilities provide the most intensive level of support, including nursing care. Supervised Living facilities have 24-hour staffing, but clients have less supervision. The RSN proposes increasing outpatient supports to clients currently in SL beds to enable them to move into more independent community housing—such as apartment complexes with no on-site staff, single-family group homes, and buildings taking Federal Section 8 housing vouchers. These funds could then be used to increase LTR beds, which will be needed as Western State Hospital continues to downsize.

VII. CONCLUSION

We have solid evidence that intensive client-centered services addressing individual concerns and aspirations are effective. We know that client input into treatment decisions, access to a variety of housing options, and opportunities for meaningful employment benefit clients. We have administrators and managers who recognize the need for better coordination of services and want to invest in recovery oriented programs. But we also have serious budget constraints and dramatic shifts in state funding. The decisions we make in resolving this tension will speak volumes about the character of our community.

APPENDIX A

King County Regional Support Network Mental Health Plan Vendors

Asian Counseling and Referral Service
Children’s Hospital and Medical Center
Community House Mental Health Center
Community Psychiatric Center
Consejo Counseling and Referral Service

Downtown Emergency Service Center
Evergreen Healthcare
Harborview Mental Health Services
Highline West Seattle Mental Health Center
Puget Sound Educational Service District
SeaMar Community Health Center
Seattle Children’s Home
Seattle Counseling Service
Seattle Mental Health
Therapeutic Health Services
Valley Cities Counseling and Consultation
YMCA of Greater Seattle

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King County Dept. of Community and Health Services
Jackie McLean, Director, DCHHS
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Marty Lindley, Chief Financial Officer, MHSADSD
Shelle Crosby, Coordinator, System Performance and Clinical Services, MHSADSD
Lisbeth Gilbert, Program Analyst, MHSADSD

King County Department of Adult and Juvenile Detention
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Kelli Nomura, Director, Marketing and Business Development
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Seattle Mental Health
Trish Blanchard, Chief Clinical Officer
Susie Winston, Director, Northwest Counseling Institute
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Conference

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